ASSESSMENT AND TREATMENT PROTOCOL IN ROTATOR CUFF TENDINOPATHY BY USING SHOULDER SYMPTOMS MODIFICATION PROCEDURE

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INTRODUCTION

Shoulder discomfort is a frequent and dangerous musculoskeletal problem that has a higher mortality rate because of the difficulty to use the upper extremity effectively (1). Rotator cuff (RC) abnormalities, Gleno-humeral joint (GH) abnormalities and Acromioclavicular (ACJ) diseases are the most prevalent reasons for shoulder discomfort, accounting for 30% of all shoulders diagnoses. Tendinopathy, tendinosis, tendonitis, bursitis, and incomplete and comprehensive cutaneous rotator cuff tears are among the many rotator cuff illnesses. Clinical shoulders diagnostic techniques cannot distinguish certain tendons or other tissues to establish a correct diagnosis because of the anatomy of an RC and the position and conduction of the subacromial bursa.

Up to 30% of the populace will suffer shoulder discomfort at some point in their lives, and up to 50 percent of the community will have at least one symptom of overuse injuries per year. Shoulder issues are fairly frequent, to say the least. A written record is taken and discussed with the patient, followed by testing and continuous monitoring for potential red-flag introductions, functional/disability quizzes, and an evaluation of deficits, which may cont a Range of ainMotion, strength, posterior capsule expandability, neurological tests, pain behaviour, and so on. Changing the stress on the muscular unit may also

ABSTRACT

BACKGROUND: Recent Orthopaedic Testing has low specificities and probability ratios will be unable to distinguish between the tendon and other components to provide an accurate diagnosis and would be unable to guide comprehensive patient therapy. This research looks at Rotator cuff tendinopathy by using a specialized diagnostics approach called the Shoulder Symptom Modification Procedure (SSMP) that figure out what was causing the problems as well as how to fix it. The therapy procedures are carried based on the above evaluation. This study offers a treatment-oriented evaluation. SSMP is a series of four mechanical techniques employed in a sequential order while performing an action that reproduces symptoms to discover one or more approaches that minimize symptoms while boosting mobility. METHOD: The study comprised 26 participants who had Rotator Cuff Tendinopathy Syndrome. Patients completed a - based test to determine the severity of their Rotator cuff tendonitis symptoms. The goal of the SSMP was to discover a method for reducing these symptoms. It’s made up of four different types of modifications: Scapular posture, humeral head position, and Neuromodulation are all examples of thoracic kyphosis. If the symptoms improved more than 30% through each modification it’s resulted in a positive outcome. RESULTS: Based on the Numerical Pain Rating Scale and the Constant Murley scale, The Mean values are 141.05, 86.05 respectively and Standard deviations are 0.8335, 1.479, and paired ‘t’ values are 15.01, 32.68 respectively indicated that SSMP demonstrated significant improvements in symptoms of Rotator cuff tendinopathy. CONCLUSION: The results of the study suggest that SSMP plays an effective assessment and treatment protocol in improving symptoms of Rotator cuff tendinopathy. The symptoms modifications are greatly achieved by thoracic kyphosis, humeral head procedures, and scapular positions.

Keywords: Rotator cuff (RC) tendinopathy, shoulder symptoms modification procedure (SSMP), Numerical pain rating scale (NPRS), Constant Murley Scale (CMS).
aid in the validation of clinical theories. The clinical assessment may be aided by orthopedic testing and imaging. However, as previously noted, the efficacy of orthopaedic testing may be limited to symptoms replication, and therapeutic communication to incriminate the part(s) based on these tests has been questioned; 54 percent of persons with shoulder issues report that symptoms persist three years later (2).

When discussing Rotator cuff problems, it's important to remember that the incidence of rotator cuff tendinopathy rises with age. The painful disease of tendon disorganization and thickening lowers the tendon's physical qualities, causing the tendon to fatigue, aggravating the painful condition and eventually leading to failure.

The Shoulder Symptom Modification Procedure (SSMP), which was initially reported in 2009, is one such strategy. The SSMP uses a battery of tests to look at the effects of thoracic attitude, 3 levels of scapular posture (and combinations of scapular placement), and humeral head position on shoulder complaints. The symptoms are subsequently treated using SSMP evaluation approaches that have been demonstrated to lesser symptoms While the first 3 cycles of the SSMP do not completely alleviate or decrease symptoms, the SSMP's last stage involves assessing the effect of physical therapy techniques in the cervical, thoracic, and shoulder regions on shoulder issues. In response to this, recommendations have been made to employ symptom modification (also known as treatment direction exam categorization test results test) as a way to guide clinical care (3).

Overuse or normal wear and tear are the most common causes. Tendonitis is another name for tendinositis. Repetitive overhead tasks might lead to rotator cuff injuries and issues. This includes weightlifting, swimming, tennis, golf, and a variety of physical vocations (4).

With shoulder movement, the rotator cuff muscle fibers are thought to be engaged simultaneously and evenly to actively stabilize the humeral head onto the glenoid fossa. The supra- and infraspinatus are activated primarily in shoulder flexion, while the subscapularis is engaged at greater levels during extension, according to laboratory studies. Greater supra- and infraspinatus engagement at shoulder flexion can help to minimize anterior humeral head glide during shoulder flexion activities, whereas subscapularis activation may help to reduce posterior humeral head glide while extension services. (5).

But even though the interwoven design of RC, capsule, and ligaments tissues increase resistance to stress failure, the independent great choice cannot be evaluated. Electromyography has shown that during the 'full' and 'empty' can test identify the supraspinatus conditions eight to nine additional muscles are similarly active, demonstrating the incapacity to test the RC musculotendinous units in isolation. This asynchronous activity might be utilized to help with workout recommendations. Furthermore, The deltoid, which is better oriented to hold the shoulder joint onto the glenoid fossa while allowing the RC to rotate the shoulder joint externally and internally, may override the cuff's stabilizing characteristic at higher levels of shoulder elevation, including such severe abduction (6).

Rotator cuff tests were developed to assess each of the tendons by placing the shoulder in various positions and applying pressure (7). However, because of its architecture, the RC does not allow for the evaluation of a single muscles and tendons unit. The supraspinatus and infraspinatus tendons of the RC merge into one structure around their insertion, and the supraspinatus and infraspinatus tendons fuse indelibly. Just anterior to the muscles and tendons junction, the muscular portions of teres minor and spinous processes merge inextricably. The RC tendons strongly adhere to the glenohumeral capsules, and the subscapularis and supraspinatus tendons merge to create a sheath that surrounds the tendon. (8).

There is some evidence, however limited, that approaches that improve symptoms within a session can be used to the mode of treatment selection and can help anticipate changes in symptoms between sessions in the cervical and lumbar areas. The SSMP is based on personal experience evidence, thus it should be implemented with caution. It is just one of several evaluation alternatives accessible to physicians. If the clinical value is established, the method must adapt and change to new and emerging research to establish the concept's dependability and to determine which aspects (if any) can be utilized to advise patient treatment. One key and plausible concept supporting the use of the SSMP is that it may help to reduce the 'danger' associated with asymptomatic motion or activity, hence increasing function by providing the individual the confidence to move.

By modifying the RC muscle-tendon length-tension connections, differences in anatomical structure correlations, neuromodulation, and semi-fibroblast responses, the SSMP may impact the symptoms associated with RCRSP. If the SSMP does not entirely resolve symptoms and the RC is suspected of being involved in the clinical presentation, a systematic and progressive exercise program is initiated. Previously, a tiered clinical care paradigm for Rotator Cuff Related Shoulder Pain (RCRSP) was reported. (9)

Previously, musculoskeletal examinations of the shoulder were dependent upon that individual aspects could be identified and treated with a mechanical procedure that compressed, stretched, or required the tissue to contract. However, it's improbable that any test won't stretch, compress, or constrict nearby tissues during surgery. This is, without confusion, one of the purposes why new studies focusing solely on the sensitivity, specificity, and accuracy rate of tests (10) have conclusively proven that, while they have a high sensitivity and reproduce symptoms, they have low specificity, limiting their versatility in constructing a definitive diagnosis. Finally, rather than anatomical diagnoses, orthopaedic special tests should be classed as pain or symptom provoking tests (11,12).

Lewis created the Shoulder Symptom Modification Procedure (SSMP) as a possible alternative to the traditional shoulder evaluation. This procedure entails determining which movement, position, or activity best replicates the patient's
symptoms. The SSMP is used once the movement or activity has been recognized and agreed upon. The SSMP is a set of mechanical procedures used to discover a mechanical alteration that may relieve symptoms or enhance the range of motion while the patient performs the activity or movement. The Neer sign has been adopted alongside other tests, such as the Hawkins' test (13) and the Internal Rotation Resistance Stress Test,”(14), as clinical ways to incriminate the acromion as the origin of presentation shoulder problems.

Clinical examination procedures for rotator cuff tendinopathy/impingement are unable to find specific tendons and other components and offer a clear diagnosis for at least three reasons. The structure of the rotator cuff, the location and innervation of the subacromial bursae (SAB), and the lack of correlation between existing imaging techniques and complaints are all instances.

Because clinical signs are similar and existing diagnostic procedures are unreliable, diagnosing the fundamental structures responsible for shoulder problems is challenging (15). The testing of the shoulder is based on the idea that orthopedic studies that apply compressively (16), stretches, or targeted contraction to specific tissues can help distinguish between different anatomical elements. (17). Clinical tests meant to measure structural stability and pain response, on the other hand, are unlikely to isolate a single tissue from nearby structures, making it difficult to establish which structure(s) are involved in the patient's complaints (18). Furthermore, some investigations have found a poor connection between symptoms and existing imaging modalities for shoulder evaluation (19,20).

Due to the lack of reliability and poor probability ratio, no single shoulder screening test now available can be recommended for making a pathological diagnosis, according to three selected analyses (21-25). Medical decision based on these possibly erroneous clinical assessment methodologies and neuroimaging data is further impeded as a result. Because of the low relevance and lack of clinical significance of existing tests, Other evaluation approaches have been developed in addition to the difficulties in obtaining an anatomy diagnostic in shoulder discomfort; nevertheless, their validity and reliability must be proven before use. (26-29).

The influence of thoracic attitude on complaints, the effect of scapular position on diagnoses, the effect of humeral head surgeries, and the impact of neuromodulation techniques make up the SSMP. Positive responses might lead to treatment. Test findings are dependent on the response to the change conducted during the assessment. The goal of this study was to see how reliable the SSMP was in patients with shoulder discomfort. The SSMP's capacity to be utilized by physicians for the assessment of shoulder discomfort would be evaluated by looking into its dependability.

Methods
Participants
The following inclusion and exclusion criteria were used to enroll individuals with rotator cuff tendinopathy symptoms:

Inclusion criteria:
Participants were above the age of 18 and had inner shoulder discomfort or symptoms that did not refer below the elbow and did not impair shoulder mobility. There was no time limit on how long symptoms may last.

Exclusion Criteria:
Systemic conditions such as rheumatism, energy metabolism, or neurologic diseases; inability to speak or provide written permission; persistent tiredness level With maternity benefit. Six cases were ruled out based on the above criteria.

Study design
The research was designed as a randomized controlled experiment. The participant's procedure was handed up to the two physiotherapists. The physiotherapist assesses the patients using the Modification of Shoulder Symptoms technique (SSMP)

Measures of success
The participants with rotator cuff tendinopathy are identified using the shoulder symptom modification technique (SSMP). The patient is informed about the evaluation methodology before the SSMP process begins.

The SSMP begins with a search for a functional test that causes the symptoms, which is then utilized as a reference for their change throughout the SSMP. A positive test result was defined as a reduction in symptoms of more than 30% as both a result of the change. The SSMP consists of four main modification categories, which are implemented in the sequence listed below:
1. Thoracic kyphosis
2. Scapular position
3. Humeral head procedure
4. Neuromodulation

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Thoracic Kyphosis Modification:
"Place your finger on your sternum and press it forward," stated the active extension instruction. To maintain a decreased thoracic kyphosis, this proactive extension was supplemented with thoracic tapes whenever the outcomes were favorable. Self-reported percent symptoms relief was used to measure the influence of these adjustments on symptoms aggravation, which was then documented.

Scapular Position Modification
Manual scapular elevation, depression, protraction, retraction, and tilt (posterior/anterior) all are examined for their effects on shoulders discomfort and mobility. When appropriate, the effect of a series of 2-3 excellent scapular motions on symptoms also was assessed. The effectiveness of hand stabilization and winging avoidance was evaluated whenever scapula winging was found.

Humeral Head Procedure
The impact of manual procedures on the humeral head is referred to as humeral head position manipulation. Humeral head depression can be assessed in several positions, including sitting, lying, and with the arm helped in elevating (flexion/abduction) by a resistance band connected around shoulder level. Other humeral head changes include external rotation, anterior-posterior (AP) pressure, and posterior-anterior (PA) pressure.

Neuromodulation Modification
It consists of four manual therapy procedures aimed at alleviating shoulder pain. The following Neuromodulation methods were carried out in a specific order:
1. In a sitting position, use a manual cervical distraction.
2. Movement-assisted Mulligan cervical mobilization.
3. Soft tissue methods over the Supraspinatus muscle area (such as stripping, friction).
4. Techniques for taping (note these were not Kinesio -taping techniques).

Assessment Procedure:
In this assessment, 20 patients with Rotator cuff tendinopathy were assessed through SSMP modifications as six patients on Thoracic Kyphosis, five patients on Scapular positions, five patients on Humeral head position, and four patients on Neuromodulation.

Intervention
The study was carried out for 1 year, the patients were evaluated by SSMP procedure by a physiotherapist. SSMP was performed for 15 to 20 minutes for each patient. After using the assessment the treatment protocol was fixed.

Treatment Protocol:
A straightforward sampling procedure was used to pick the subjects. There were a total of 20 participants that met the inclusion and exclusion criteria. The study was explained to the subjects in detail, and signed informed permission was acquired from those who met the requirements. Each person was assessed both before and after the exam. Treatment time is 30 minutes, with three sessions each week.

1) Thoracic kyphosis
The patients who are having shoulder pain due to thoracic kyphosis are concentrated on the thorax.
- FINGER ON STERNUM TECHNIQUE - Instruct the patient to "put your finger on your chest and push forward again" to aid with kyphosis reduction.
- TAPING- (A) Tell patients to stand up and extend the crown of his or her head towards the ceiling. (B) Use a cover roll to protect the surface as needed. (C) Pertain medicinal tape diagonally across the spinous process of T6 from the anterior portion of the acromion to the muscular mass of the upper trapezius. (D) Use this approach to apply tape bilaterally, crossing the strips of tape.
- MANUAL THERAPY - Trigger Point Therapy, Active Release Techniques: A practitioner uses touch to detect where adhesions are located, then combines the patient's active movement with his or her touch.
- ILLIOPSOAS – Stretching and trigger point release techniques.
- OTHERS-1) Traction 2) Massage 3)Bracing
2) SCAPULAR POSITIONS-
- Scapular retraction (squeeze shoulder blades) Relax your head and neck, stand tall, and squeeze your shoulders back. Shoulders should not be shrugged. Hold for 10 seconds while keeping your abs firm. The shoulder should be relaxed. 3 times a day, 10 repetitions, 2 sets.
- External rotation - Roll shoulders back and down and hold this posture using a resistance band attached to a steady object at waist level. Place a cloth between your elbow and the side of your body. Slowly rotate your hand away from your stomach. Hold for 3 seconds and then repeat 12-15 times for a total of one set, three times each day.
- Physioball scapular exercise- Stand with one hand on the ball and the other on the wall. Slowly roll your hand up and down as you bring your shoulders back and down. 3 times a week, perform three sets of 15 repetitions with your shoulders back and down.

3) WINGING SCAPULA –
Training the M. serratus anterior, face the wall with your back to it, knees slightly bent, and feet shoulder-width apart. The elbows are flexed to 45 degrees, the arms are abducted 60 degrees away from the trunk, and the shoulder is internally rotated to 45 degrees. The patient next repeats horizontal adduction of both upper extremities, following an imaginary arc at roughly 60 degrees of elevation until maximal scapular protraction is achieved by placing their hands together in a hugging gesture around a cylindrical object. You then return to your starting position.

4) HUMERAL HEAD PROCEDURE –
- Isometric shoulder flexion. Place yourself against a wall. Make a fist with the elbow on the side of the shoulder you wish to train. Among your fists and the wall, place a wrapped towel and gently push your palm into the wall. Hold for five seconds before releasing carefully.
- Isometric Shoulder Abduction, Stand approximately six inches away from a wall and turn your body parallel to it. So should exercise the shoulder that is closest to the wall. Form a fist and slam it against the wall. For added comfort, you might choose to use a folded blanket. Apply pressure into the wall as if trying to lift your arm out towards the sides, and maintain for 5 seconds. Release pressure on the wall gradually.
- Isometric Shoulder External Rotation. Stand firmly 6 inches away from a wall, perpendicular to it. The shoulder you're working on should be the one that's closest to the wall. As though you were turning your arm outwards, bend your elbow 90 degrees, create a fist, and push the palms of the hands into the wall. If necessary, provide some cushioning with a tiny towel. For around five seconds, gently pushes against the wall. Slowly relax pressure on the wall; if you experience any greater discomfort, stop the activity.
- Isometric Shoulder Internal Position your body such that you're facing a garage door or a structure’s exterior corner. The shoulder you're working on should be near a doorway or a corner.
- Bend your elbow 90 degrees, create a fist, and press down into a corner wall or door frame as if trying to spin your hand inside toward your belly. Remember that your shoulder must not move during the activity. For cushioning, use a small wrapped cloth. Hold down the button for five seconds before gently releasing it.
- Isometric Shoulder Extension. With your back to the wall, stand approximately six inches away. Maintain a straight elbow with your hand near your hip. Make a fist and gently push it against the back wall. Remember that your shoulder should have very minimal movement. Hold the pressure on the wall for five seconds before progressively releasing the pressure.

1) NEUROMODULATION MODIFICATION
- Manual cervical distraction. The participant lies prone on a load-instrumented table with just an adjustable headgear that allows for directed head movement while recumbent. At a given vertebral level, the clinician softly grasps the posterior region of the participant's neck with a broad touch (contact hand) among the thumb and index finger. The physician comprehends the controlling handle with the other hand. Using the contact hand, the therapist maintains superior traction at a single vertebral level while ensuring a smooth motion via touch with the control handle. The idea is to generate a localized distractive movement that is slow and rhythmic (1-3 seconds). Only axial distraction will be employed in this study.
- Mulligan’s cervical mobilization: The patient is in a sitting position. The therapist’s position stands beside the patient, cradling his or her head between your body and your right forearm (when you stand at his/her right side).
- Application: Starting at the base of the occiput, place your right index, middle, and ring fingers. The middle phalanx of the same hand, as well as the little finger, are positioned above C2's spinous process. Then, on top of your right little finger, put the lateral border of the left thenar eminence. The spinous process of C2 is now gently pressed in a ventral direction, while the skull stays still owing to your right forearm's control. (The mild moving power originates from your left arm, via the thenar eminence above the little finger on C2's spine.)
- The index finger's pressure pushes the lower vertebra forward under the rib cage.

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• Soft tissue techniques: Soft tissue mobilization works by breaking up scar tissue by mobilizing muscles. Mobilizations also aid in the removal of toxins from the wounded region, speeding up the recovery process. Soft tissue mobilization also aids in the release of muscular tension, increasing flexibility and range of motion.

Statistical Analysis
The data were evaluated by using paired `t-test. The paired `t-test was used to find out the statistical significance between pre and post-test values of the numerical pain rating scale(NPRS) and Constant Murley scale (CMS) for the rotator cuff tendinopathy patients.

The average of the two was determined for all of the outcome measures in the group before and after training, and the Standard deviation was used to assess how much they differed. To examine if there was any variance within the group, the Mean difference was computed.

Result:
The study sample comprises 26 patients with rotator cuff tendinopathy, 6 subjects were excluded, and 20 subjects underwent the She shoulder symptom modification procedure. The pre and post value is assessed by the Numerical pain rating scale (NPRS) and constant Murley scale (CMS).

The mean difference value is 141.05 and 86.05 respectively. The standard deviation is 0.833 and 1.479 respectively the paired test value is 15.01 and 32.68. This data suggests that modifying shoulder symptoms can help assess and manage Rotator cuff tendinopathy

The participants demographic and Graphical Representation were presented in Figure1

There is a significant assessment and treatment protocol in rotator cuff tendinopathy by using shoulder symptoms modification procedure.

DATA PRESENTATION:
Table 1: Data presentation between Numerical Pain Rating Scale and Constant Murley scale

<table>
<thead>
<tr>
<th>Data values</th>
<th>Numerical Pain Rating Scale</th>
<th>Constant Murley scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean difference</td>
<td>141.05</td>
<td>86.05</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>0.833</td>
<td>1.479</td>
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<tr>
<td>t-test</td>
<td>15.01</td>
<td>32.68</td>
</tr>
<tr>
<td>Table value</td>
<td>2.15</td>
<td>2.15</td>
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</tbody>
</table>

Figure 1: Mean and Standard Deviation between outcome measures

SD: Standard deviation, MD: Mean difference, CMS: Constant Murley scale, NPRS: Numerical Pain Rating Scale

Discussion:
While consideration of improving symptoms in patients with Rotator cuff tendinopathy, I will be found there was an effective and improvement in symptoms with Rotator cuff tendinopathy. The Rotator cuff tendinopathy cases are not their problem in the Rotator cuff muscles and are also integrated with surrounding structures consist the shoulder, scapula, and iliopsoas muscle so that the treatment focus on the reliable causes that we are using the Shoulder Symptom Modification procedure.

According to o Lewis J S et al (2010) explanation Is it ready for a fresh evaluation strategy for rotator cuff tendinopathy and subacromial pinching syndrome? The procedure finally leads to the formulation of clinical hypotheses, which are then determined upon and executed in collaboration with the patient.

According to SARIG BAHAT H, KERNER O et al (2016) explained. A Reliability Study of the Shoulder Symptom Modification Procedure (SSMP) The results of the study revealed good overall dependability, with high reliability for thoracic and humeral head alteration alone. Due to the dynamic nature of the variable being analyzed, dependability was probably reduced. As a result of the alterations, the severity of the symptoms may have changed, altering the response to the prompting in the second innings. More research is needed to discover if strategies that address the identified constraints might increase dependability.

According to JEREMY S LEWIS, KAREN MCCREESH, EV BARRATT, ERIC J HEGEDUS, JULIUS SIM, et al (2016), The shoulder symptom management procedure's mutually dependent dependability in persons with shoulder discomfort. Although it is difficult to provide a definite anatomical diagnostic for a person with a neuromuscular issue involving the shoulder, the results of this study reveal that the SSMP has a high level of reliability. More study is required to fully comprehend the significance of such methods.

According to GREGORY J LEHMAN et al (2018), The role and value of symptom modification approach musculoskeletal practices. Symptomatology modification is a frequent method in modern musculoskeletal treatment. It arose from the awareness that finding the structural origins of symptoms is often impossible and that creating mobility alterations depending on kinematic and kinetic principles may be unneeded and unjustified.

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According to KIM GORDON INGWersen, STEEN LUND JENSEN, LILLI SORENSEN, HANS RI JORGENSEN, ROBIn et al (2017), In individuals with rotator cuff tendinopathy, 3 months of progressively high load strength training vs typical low load strength training was compared. The primary outcomes of the double-blind study. Individuals with RC tendinopathy can't benefit more from PHLE than from regular LLE, according to the findings. To create an appropriate and possibly synergy combination of these two factors, more research into the probable interaction between exercise style and corticosteroid injection is required.

According to ORNA KERNER et al (2013) The shoulder symptom modification technique's dependability (SSMP). According to recent research on the sensitivity, specificity, and accuracy rate of should exams, so they have a high sensitivity and match symptoms, they have a poor susceptibility, which reduces their utility in making an accurate diagnosis and treatment.

According to DlEGO RISTORI, SIMONE MIELE, GIACOMO ROSSETTINI, ERICA MONALDI, DlEGO ARCERI, MARCO TESTA et al (2018) Towards a comprehensive clinical framework Patient suffering from shoulder ache. The suggested therapeutic approach, which is based on a bio-psychosocial view of health, incorporates diagnoses, pain causes and expectancies.
interests, and psychosocial aspects of patients to help physiotherapists perform a diagnostic assessment and determine the best therapy for each patient.

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The study has prepared the Shoulder Symptoms Modification Procedure (SSMP) not only improves the functional abilities but also the performance of the Rotator cuff in Rotator cuff tendinopathy patients.

The Shoulder Symptom Modification Procedure helps alleviate the symptoms of Rotator cuff pathology, and we must adhere to the strength routine regularly to improve therapeutic efficacy.

Finally, it can conclude that, if patients need their Rotator cuff more functionally to improve strength as well as supporting muscles.

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